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ANDOVER
RURAL DISTRICT COUNCIL

Annual Report

of the

Medical Officer of Health

FOR THE YEAR 1952

COUNCIL OFFICES, JUNCTION ROAD, ANDOVER
HANTS

Printed by
The Standard Press (Andover) Ltd.
Telephone 2413

PUBLIC HEALTH OFFICERS

Medical Officer of Health :
JOHN SLEIGH, M.B., Ch.B.(Aberd.), D.P.H.(Edin.)

Chief Sanitary Inspector :
R. J. RICHARDS, A.I.A.S., M.R.San.I., M.S.I.A.

Additional Sanitary Inspector :
J. A. DEAN, M.R.San.I., M.S.I.A.

TO THE CHAIRMAN AND MEMBERS OF THE ANDOVER RURAL DISTRICT COUNCIL

Mr. Chairman, Ladies and Gentlemen,

I have the honour to present my Annual Report for the year 1952.

In 1951* over 3,250,000 patients were treated in hospitals, 173,000 more than in 1950, and 322,000 more than in 1949. The number of whole-time consultants rose from 1,310 in 1949 to 1,605 in 1951, and of part-time consultants from 3,879 to 4,274. During that same period of two years, the total medical and dental staff in the hospital service went up from 8,954 whole-time members to 10,245, and from 20,280 part-time members to 23,281. Nearly 14,000 more hospital beds were brought into use, and hospital nursing staff increased by over 13,000. There was no halt in the persistant rise in both the number and cost of doctors' prescriptions, which in number went up from 217,000,000 in 1950 to 228,000,000 in 1951, and in average cost from 3s. 1d. at the beginning of 1950 to about 3s. 11d. each at the end of 1951. Five doctors' prescriptions were issued on the average in one year for every man, woman, and child in the country. The number of prescriptions rose from 10¾ million in the first month of the Service to not far short of 17 million a month in the summer of 1951, and in January of that year during an influenza epidemic, it reached the astonishing figure of just on 29 million.

When this report was published some nine months ago, the account of it given in the Press and on the wireless gave the impression that it was a great testimonial to the National Health Service, but I would submit that there are other ways of looking at the matter than this. Let us start by examining the question of cost.

Cost of the National Health Service in Millions of Pounds

	1950–51	1951–52	1952–53	1953–54
Local Health Authorities	16.8	18.6	21.2	21.6
General Practitioner Service	47.4	48.4	57.6	58.2
Pharmaceutical Dental and Ophthalmic Services	106.4	94.4	67.6	73.4
Regional Hospital Boards	251.1	274.3	296.0	297.1
Total	421.7	435.7	442.4	450.3

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* Report of the Ministry of Health, 1st April, 1950, to 31st December, 1951, Part I.

It will be remembered that four years ago the then Government decided to set a limit of £400 million on the amount that was to be spent annually on the National Health Service. Two years ago the present Government imposed certain charges for the pharmaceutical, dental, and supplementary opthhalmic services, in a further attempt to keep the cost of the Service within bounds. The above figures show just how successful both Governments have been in achieving their object. The total spending on the Service is somewhere about 3½% of the total national spending on goods and services, and unless further charges are imposed so that less and less of the Service remains to be paid for from taxation the cost will continue to rise year by year and will continue to account for an increasing proportion of the total national spending.

Percentage of the Total spent on the four Services in each year

	1950–51	1951–52	1952–53	1953–54
Local Health Authorities	4.0	4.3	4.8	4.8
General Practitioner Service	11.2	11.1	13.0	12.9
Pharmaceutical Dental and Ophthalmic Services	25.2	21.7	15.3	16.3
Regional Hospital Boards	59.6	62.9	66.9	66.0
Total	100.0	100.0	100.0	100.0

There are two points here to which I would like to draw attention. The first is the quite disproportionately enormous amount spent on the Hospital Service (two-thirds of the total) and the quite disproportionately small amount spent on the Local Health Authority Service (less than 5% of the total). The Hospital Service makes the least contribution to the promotion of health and the prevention of disease, being concerned almost entirely with the treatment of disease, the Local Health Authority Service makes the greatest contribution to the promotion of health and the prevention of disease. The other point is that the only effect of the charges made for the pharmaceutical, dental, and supplementary opthalmic services was to divert the money into the ever-willing maw of the hospital service. As the amount of money and percentage of the total devoted to these three services was reduced, so was that devoted to the hospital service increased. Over the four years the combined totals of the two in terms of money were £357.5, £368.7, £363.6, and £370.5 millions, and in terms of percentages 84.8, 84.6, 82.2, and 82.3. It is the hospital service that is the cause of the enormous cost, and of the increasing cost, of the National Health Service.

These astronomical figures for numbers sick, and for the cost of their treatment, are at the same time a very clear indication that whatever the death rate may be there is certainly something very far wrong with the sickness rate. Furthermore the fact that the numbers sick and the cost of their treatment is rising year by year seems to suggest, as many people have believed all along, that a healthy community cannot be achieved by treating the sick, and in fact that increased facilities for treatment will only whet the demand for still greater facilities.

In previous annual reports I have quoted Dr. Ffrangcon Roberts, who seems to have a clearer idea than anyone else of the fact that the treatment of disease is something that will inevitably increase. Here is another quotation from Dr. Roberts,* " The phenomenal increase in the progress of medical science, with its attendant increase in cost, far outstrips any possible increase in production by which alone it can be financed." So long as we try to achieve health by treating disease, so long must we expect to spend an increasing proportion of our national income on the treatment of disease, for the increase in scientific knowledge is something which will continue at an accelerating rate and the cost of the treatment of disease will increase as research and therapeutics become ever more elaborate and expensive. All the time we find more methods of diagnosis and new means of treatment, necessitating more hospitals, more nurses, and more doctors, and longer training for these. If it were economically possible for this inevitable and increasing acceleration to continue the whole population would ultimately be working a 24-hour day looking after the sick.

The attempt four years ago to put a ceiling on expenditure on the National Health Service and the further attempt two years ago to curtail expenditure by making certain charges, indicated that the economic aspects of the present situation were beginning to be appreciated. I do not know whether it is yet realised that if we try to achieve health by treating the sick, we must expect to spend at an increasing rate year by year, but even from year to year as the cost of the Service rises, the voice of the economists is going to be heard more and more. If the present policy continues, the National Health Service is going to make an increasingly excessive demand on our production and on our labour force. If the Service gets more, then other things must get less, and many people would say that food, shelter and education, to give only three examples, were more important than the National Health Service. I have discussed elsewhere in this report the effect of the diminishing birth rate on the proportion of producers in the community and figures on this subject can be found on page 11, but without going into detail here, the fact is that the proportion of producers is steadily contracting, and that it would be better that they should be in productive employment than in non-productive employment as in the National Health Service. Furthermore, in doctors and nurses, the Service demands material of above-average quality so that its call on our manpower resources is greater than mere numbers suggest. Exactly the same arguments apply to the demand that the Service makes on our production and on our material resources. Again, I have indicated elsewhere in this report (page 5) the particular difficulties of our economic situation with reference to Housing, that Housing must take its place in the queue of priorities behind home food production and exports to pay for imported food, and that there is a buyers' market for exports and a sellers' market for food. I suppose half as much again is spent on the National Health Service as on Housing, and I am equally sure that Housing should be before, not after, the Service.

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* " Medical Officer," 1953, I, 239.

There is the problem. What then is the solution ? Dr. Roberts suggests that we should develop some system of priorities, when treatment would be provided in proportion to the recipient's ability to return, in the form of service, its cost to the community. There is however another answer to this problem than that of allocating treatment only where there will be a corresponding return. The doctrine of original disease has come to be accepted by Man, and it never occurs to us to question whether Nature might not have meant us to be healthy. We accept sickness and disease as inevitable and devote our medical services almost entirely to their investigation and treatment. We never stop to question why the incidence of disease is so different in different countries, or even in different parts of the same country. This subject and suggested cause and remedy are discussed on page 18.

Our research should be into health and its attainment, not into disease and its treatment. The treatment of a disease in one individual does nothing to prevent another from acquiring the same condition, nor even to prevent the first from becoming ill again, when he returns to the environment (of which food is the most important part) which made him take ill in the beginning. It may be argued that such research will be as complex and unrewarding as is our present research. But I believe that what we are going to find in every case is that it was where we went astray from Nature that we were wrong, and that it is only in the direction of aberrations from Nature that we need look for the cause of disease.

HOUSING

Once again it is appropriate to include some words on Housing in the Annual Report. The Medical Officer of Health is concerned with all matters affecting the health of the community and housing is still by far the most important of these and so far as can be seen will continue to be for an indefinite period. But whereas food rationing for example affects all members of the community, the housing shortage affects only those who require to be rehoused and the likelihood of the politicians taking the same degree of interest in the housing shortage as in food rationing is lessened, because only a minority of the electorate are concerned with the one, whereas the whole electorate are concerned with the other. 209,000 houses were built in England and Wales in 1952, which is a welcome improvement over the figure for 1951, 172,000. However I repeat once again that there is a very long way to go before we reach the figure for 1938, the last pre-war year, which figure was 344,000 for England and Wales. Houses are needed far more now than they were then, and if 344,000 were built in 1938, it should be possible to build more than 209,000 in 1953. I would also repeat once more that 183,000 houses are required each year for replacement purposes, and that out of the 209,000 that were built last year only 26,000 could really be regarded, from the point of view of the community as opposed to that of individual families, as being additional houses. No wonder lists of prospective Council tenants increase steadily.

However, as I tried to indicate last year, the problem of housing our people is primarily economic and I do not think the implications of this are fully realised. We are told there is a dollar shortage as if this was due to bad luck, if not to the inexplicable workings of high finance. The plain truth is that there is a dollar shortage because we cannot earn enough dollars by our exports to the dollar area to pay for our imports from the dollar area. We buy more from the dollar area than the dollar area buys from us and so we have an adverse trade balance. The purpose of devaluation was to make our goods more attractive in the dollar area by reducing their price in dollars by 25%, but it also meant that we had to export 33% more to the dollar area in order to earn the same amount of dollars as before, and so to be able to buy the same amount of goods. Our first requirement is food, and our first objective must be to expand home food production, (it would be better to develop marginal land in this country and get more beef and dairy products than to spend money in tropical Africa trying to produce ground nuts and poultry with no result), but after that the second call on our resources must be to produce exports to pay for imports and for the raw materials needed to manufacture further exports. Housing must expect a smaller slice of the cake than it did before the war. A poor man has to spend more of his income on food than a rich one. If we need 183,000 houses a year for replacements and if we cannot build as many houses as we would like, then perhaps some people will have to do without, unless we build sub-standard houses which would be wasting materials and labour and making no contribution to solving the housing problem. The politicians are not inclined to look beyond the life of the current Parliament, and short-term considerations are liable to have preference over long-term ones, but the housing problem is as serious as ever, and is by no means solved yet.

Last year I said something about housing allocation and I do not think that some further comment on this subject is out of place. Some Authorities operate a Points Scheme, others do not. Unless houses are allocated on the basis of groups of applicants small enough for those allocating them to have a mental picture of the circumstances of all those applying, it is difficult to see how a Points Scheme can be dispensed with, and this criterion is only likely to be met in the case of a very small Municipal Borough or Urban District or in that of a parish. Allocation on the basis of a parish is not entirely satisfactory because it is difficult to estimate the respective requirements of the various parishes in a Rural District and because in any case it may not be possible to find sites adequate for the requirements of the parish, or in fact, sites at all in every parish. Points Schemes do therefore seem to be of real value in most instances, and if it is found that families come to the top of the list who manifestly do not need rehousing, or that families do not come to the top of the list who manifestly do need rehousing, so that discretionary points have to be awarded fairly frequently, then there is something wrong with that Scheme in particular, not with Points Schemes in general. It should not be necessary to award discretionary points too frequently and the fact that discretionary points have to be awarded in a deserving case means that it is possible to ignore a deserving case by not adding points. Houses should be allocated primarily on a basis of need, and sufficient points should be allocated for the factors relevant to need to ensure that they are not outweighted by the factors not relevant to need. There is no obligation on a Council to house families whom it would not welcome, and there is no need for a Points Scheme which will prevent such families reaching the top of the list. Exactly the same considerations apply whether a Points Scheme has been adopted or not, and such weight should be given to such factors as overcrowding, sharing a house, insanitary conditions, ill health, and children, as to ensure that they are not-outweighted by such other factors as war service, residence, employment, and date of application. It has been recommended by the Central Housing Advisory Committee that the first list of factors should be regarded as basic and the second list should be used only in distinguishing between families who are equal with one another as far as the first list is concerned. Once again I would like to stress particularly the case of families with children. There appears to be no justification for housing families without children before families with children. A family's difficulty in obtaining accommodation is in direct proportion to the number of children, and families without children should not be considered until those with children have been satisfied, unless their present accommodation is to be used for families with children, and other things being equal, families should be considered in order of number of children.

There are at present in occupation in this Rural District 176 ex Services Huts and the Hobhouse Survey disclosed that 289 houses were unfit and unsuitable for reconditioning. It is now more than seven years since the end of the war and the Huts are no longer fit to live in. At the same time the unfit houses are deteriorating and in my view the time has now come to consider setting a definite limit to the period within which all these tenants should be rehoused, and rehousing the appropriate proportion each year. The longer a decision is delayed, the larger will be the task, because each year a further quota of unfit houses will be added and will require treatment in the same way.

Finally it may of interest to compare the number of houses built in Andover Rural District (population 17,590) since the end of the war with the number which might have been expected had houses been built at the same rate as in all Rural Districts (population 8,467,660). 197,184 permanent houses were built by public and 47,762 by private enterprise, and 9,998 temporary houses were built by public enterprise (total 254,944) up to the end of 1952 and on that basis 409 permanent houses might have been built by public and 99 by private enterprise and 21 temporary houses might have been built by public enterprise (total 529) in Andover Rural District. The actual figures were 379 permanent houses built by public and 98 by private enterprise and 32 temporary houses built by public enterprise (total 509) giving 93%, 99%, 152%, and 96% respectively of what might have been been expected, or 4% below average overall.

The figures for 1952 alone however are even less satisfactory. 40,148 permanent houses were built by public and 8,420 by private enterprise (total 48,568) and on that basis 83 permanent houses might have been built by public and 18 by private enterprise (total 101) in Andover Rural District. The actual figures were 60 permanent houses built by public and 9 by private enterprise (total 69) giving 72%, 50%, and 68% respectively of what might have been expected, or 32% below average overall.

I am indebted to Mr. R. J. Richards, A.I.A.S., M.R.San.I., M.S.I.A., Chief Sanitary Inspector, for his assistance in the preparation of this report (Sections C, D and E).

I have the honour to be,
Mr. Chairman, Ladies and Gentlemen,
Your obedient servant,
JOHN SLEIGH.

SECTION A

STATISTICS AND SOCIAL CONDITIONS OF THE AREA

(1951 FIGURES IN BRACKETS)

Area (in acres)	67,811	(67,811)
Registrar General's estimate of resident population	19,690	(17,590)
Number of inhabited houses according to Rate Books	3,798	(3,734)
Rateable value	£99,631	(£91,872)
Sum represented by a penny rate	£415	(£383)

Chief Industries carried on in the area :

Below are given Ministry of National Insurance figures of numbers employed, obtained from the Ministry of Labour. It is not possible to give figures for the Rural District of Andover as Ministry of National Insurance areas are based not on existing Local Government areas, but on the towns and the areas of country draining naturally into them. The figures given are for the area of the Andover office of the Ministry of National Insurance, which area comprises :

Andover Municipal Borough

Andover Rural District

Hurstbourne Priors, Laverstoke, St. Mary Bourne, Whitchurch, and Portals only in Overton, in Kingsclere and Whitchurch Rural District.

Broughton, Houghton, Leckford, Longstock, Nether Wallop, Over Wallop, and Stockbridge in Romsey and Stockbridge Rural District.

Paper making and Printing	1,729
Agriculture	1,452
Building and Civil Engineering	1,193
Distributive trades	1,084
Local and National Government	1,068
Engineering, Garages, etc.	941
Transport	679
Professions	539
Food and Drink, etc.	497
Woodwork, etc.	386
All others	2,057
TOTAL	11,625

Extent of Unemployment :

This compares very favourably with that for England and Wales (0.6% as against 1.8%).

VITAL STATISTICS

(1951 FIGURES IN BRACKETS)

	Andover R.D.		England and Wales	
Births :	Rates per 1000 Home Population			
Live births	14.9	(17.1)	15.3	(15.5)
Still births	0.51	(0.40)	0.35	(0.36)
	32.9(a)		22.6(a)	
Deaths :				
All causes	6.6	(8.1)	11.3	(12.5)
Typhoid and paratyphoid	0.00	(0.00)	0.00	(0.00)
Whooping cough	0.05	(0.00)	0.00	(0.01)
Diphtheria	0.00	(0.00)	0.00	(0.00)
Tuberculosis	0.00	(0.17)	0.24	(0.31)
Influenza	0.00	(0.00)	0.04	(0.38)
Smallpox	0.00	(0.00)	0.00	(0.00)
Acute poliomyelitis (includ- polioencephalitis)	0.00	(0.06)	0.01	(0.00)
Pneumonia	0.10	(0.45)	0.47	(0.61)
Notifications (Corrected) :				
Typhoid fever	0.00	(0.00)	0.00	(0.00)
Paratyphoid fever	0.00	(0.00)	0.02	(0.02)
Meningococcal infection	0.00	(0.00)	0.03	(0.03)
Scarlet fever	0.20	(0.91)	1.53	(1.11)
Whooping cough	1.07	(2.05)	2.61	(3.87)
Diptheria	0.00	(0.00)	0.01	(0.02)
Erysipelas	0.00	(0.00)	0.14	(0.14)
Smallpox	0.00	(0.00)	0.00	(0.00)
Measles	0.51	(17.79)	8.86	(14.07)
Pneumonia	0.10	(0.06)	0.72	(0.99)
Acute poliomyelitis (including polioencephalitis)				
Paralytic	0.05	(0.00)	0.06	(0.03)
Non-paralytic	0.00	(0.00)	0.03	(0.02)
Food poisoning	0.00	(0.00)	0.13	(0.13)
Puerperal pyrexia	0.00(a)	(3.25)(a)	17.87(a)	(10.66)(a)
Deaths :	Rates per 1000 Live Births			
All causes under 1 year of age	6.8	(33.2)	27.6	(29.6)
Enteritis and diarrhoea under 2 years of age			1.1	(1.4)

(a) Per 1000 Total (Live and Still) Births.

VITAL STATISTICS

Birth Rate :

The Birth Rate for 1952 (14.9 per 1000) was 0.4 per 1000 below that for England and Wales (15.3 per 1000). If the rate is standardised to allow for the differing age and sex distribution of the population in Andover Rural District as compared with that in England and Wales it is increased to 19.5 per 1000. While the fact that the standardised birth rate is higher than that for England and Wales is an indication that more babies were born than might have been expected on the basis of the age and sex distribution of the population in Andover Rural District as compared with that in England and Wales, the fact that the standardised birth rate is higher than the crude birth rate is an indication that the age and sex distribution of the population in Andover Rural District tends towards fewer births as compared with that in England and Wales.

Until recently, as a result of the Registrar General's refusal to publish net reproduction rates, I had thought that the number of children being born was only about three quarters that necessary to maintain the population at its present level, and that when the present increase in the expectation of life ceased as it must do when all die of old age, a position from which we are not very far distant today, the population would fall by a quarter in each generation. Certainly before the war, when the birth rate was about the same as it is today, that was the position which existed, but in spite of an appeal to the Registrar General he refused to give figures for the net reproduction rate in recent years. However, as a result of recent correspondence in the " Medical Officer,'* the Registrar General has now revealed that the difference between the net reproduction rate and the effective reproduction rate, which is the rate published by the Registrar General, is much less than had been thought, and that in fact improvement in mortality has been such that births are around the 100% replacement level and that a dramatic fall in population is not at present foreseen.

This however is only half the story, as a birth rate which before the war was sufficient only to provide 75% replacement can only become sufficient to provide 100% replacement at the cost of a very considerable shifting in the balance of the population towards the older age groups, and this in fact is what is happening. Whereas in 1931 the percentages of men and women aged 15–34 were 33.8 and 33.0 respectively, in 1951 they were 27.9 and 26.9 respectively, and whereas in 1931 the percentages of men and women aged 65 and over were 6.6 and 8.1 respectively, in 1951 they were 9.3 and 12.3 respectively.† In the same way whereas in 1951 22% of the population were under 15, 67% aged 15–65, and 11% aged over 65, in 1971 20% will be aged under 15, 66% aged 15–65, and 14% aged over 65.* These changes may not seem very great, but their significance is more clearly seen when they are viewed in the light of the observations of the Ministry of National Insurance.† In 1953–54 retirement pensions will cost nearly £350 million a year out of a total expenditure from the fund of £540 million, but in 25 years time, retirement pensions will cost nearly £700 million out of expenditure of £950 million. The income from the fund will remain constant at about £530–£550 million a year, but expenditure will begin to outstrip income by 1954–55, and from then onwards the gap will increase rapidly to £100 million a year by 1957–58 and £420 million a year by 1977–78. The effect of the increasing number of retirement pensions is illustrated by the fact that while the immediate cost of the increase in pensions provided by the Act of 1952 is £30 million a year, it will be nearly double that amount in 25 years time.

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* " Medical Officer," 1953, I, 225 and 236.

† Census 1951, Great Britain. 1% Sample Tables, Part I.

It is easily seen therefore, that the burden on the decreasing proportion of producers will become steadily heavier as the years go by. It might be said that the answer would be to produce more children, but that would result in increasing our population, and we are hard put to it to find buyers for our exports and so to pay for the food and raw materials to convert into exports, that we must have or 20,000,000 of our population whom we cannot feed will starve. The trouble is that people are living too long (viewed from the economic point of view) and it is not entirely surprising that one speaker at the Royal Sanitary Institute Congress should have made a passing reference to euthanasia.‡ Personally I cannot see how euthanasia, except for incurable disease, could ever become an accepted policy, but at any rate something will soon have to be done about the age of retirement. It seems completely unreasonable for example that women whose expectation of life is five years longer than that of men (70.88 as against 65.84),|| should retire five years earlier, and a start might well be made by making the age of retirement the same for both sexes. Increasing the age of retirement beyond 65 for both sexes seems attractive, but while many people are useful citizens at 80, there are many others who are only too ready for retirement at 65. Making 65 the fixed age avoids the making of invidious distinctions. There is also the question of promotion of younger people being retarded by the retention of older people in their posts which could perhaps be overcome by those over 65 being

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* " Public Health," 1952–53, 58.

† Report of the Ministry of National Insurance for the year 1951.

‡ " Medical Officer," 1953, I, 198.

|| Registrar General's Quarterly Return No. 416, Fourth Quarter, 1952.

retained in subordinate employment, and the far wider question of national policy in all fields being influenced by the increasing preponderance of the elderly which already seems to be the case in the amount of welfare work done among the aged as compared to that done among the young. This matter of the ageing of our population is something of which the ultimate effects are quite unforseeable. Public health and therapeutic medicine have enabled men to live longer. In primitive communities this has resulted in an increase of population which is straining available food resources to the uttermost, in highly civilised communities lowered reproduction rates have restrained this population increase but have produced the problems of ageing populations of which I have tried to give some indication.

Death Rate :

The Death Rate for 1952 (6.6 per 1000) was 4.7 per 1000 below that for England and Wales (11.3 per 1000). If the rate is standardised to allow for the differing age and sex distribution of the population in Andover Rural District as compared with that in England and Wales, it is increased to 8.3 per 1000. The fact that the standardised death rate is lower than that for England and Wales is an indication that fewer deaths occurred than might have been expected on the basis of the age and sex distribution of the population in Andover Rural District as compared with that in England and Wales, and the fact that the standardised death rate is higher than the crude death rate is an indication that the age and sex distribution of the population in Andover Rural District tends towards fewer deaths as compared with that in England and Wales.

Infant Mortality Rate :

The Infant Mortality Rate for 1952 (6.8 per 1000) was 20.8 per 1000 below that for England and Wales (27.6 per 1000). No significance should be attached to a rate of this size for a small authority.

Analysis of Mortality and Case Rates for Certain Infectious Diseases :

No significance can be attached to the rates given for this authority as the population is too small. It is hoped however that it will be of some interest to compare them with those for England and Wales. The one death from whooping cough which is represented by the death rate of 0.05 should serve as a reminder if one were needed, that from the point of view of the community, whooping cough is a more serious complaint than poliomyelitis. The whooping cough and measles case rates for this year are lower and for last year are higher. This is due to the fact that although these diseases occur more or less equally each year for the country as a whole, they occur in each area every two to four years for whooping cough and every two years for measles, as it takes that period for the level of immunity in the population to fall as a result of new births to the point at which an epidemic can recur.

The following table* may be of interest as showing the importance of poliomyelitis relative to other infectious diseases.

	Number of deaths	Death rate per million
Influenza	15,809	361
Tuberculosis, respiratory	12,031	275
Tuberculosis, other forms ..	1,775	41
Gastro-enteritis	1,457	33
Whooping cough	456	10
Measles	317	7
Meningococcal infections ..	298	7
Poliomyelitis, acute	217	5

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* Annual Report of the Chief Medical Officer of the Ministry of Health for the year 1951.

VITAL STATISTICS 1951–52

Year	Population	%	E. & W.	Births	B.R.	E. & W.	Deaths	D.R.	E. & W.	I.M.	I.M.R.	E.&W.
1951	17590	100	100	301	17·1	15·5	142	8.1	12.5	10	33·2	29.6
1952	19690	111.9	100.3	294	14·9	15·3	130	6.6	11.3	2	6.8	27.6
Total				595			272			12		
Average					16.0	15·4		7·4	11.9		20.0	28.6

Population, 1952	19690	Births, 1951–52	595	Total Increase	2100
Population, 1951	17590	Deaths, 1951–52	272	Natural Increase	323
Total Increase	2100	Natural Increase	323	Immigration	1777

VITAL STATISTICS, 1951-52

I have not this year repeated the table giving Population, Population expressed as a percentage of the 1938 Population, Population of England and Wales expressed as a percentage of the 1938 Population, Births, Birth Rate, Birth Rate of England and Wales, Deaths, Death Rate, Death Rate of England and Wales, and Infant Mortality, Infant Mortality Rate, Infant Mortality Rate of England and Wales, for each year from 1938, the last complete prewar year. This table can be consulted, if desired, in last year's report. Instead I include a table giving the same information but taking 1951, the census year, as the base year, so that there is only one other year, 1952, to compare with it this year.

Population :

The percentage increase in population for Andover Rural District for 1951–52 was 40 times as great as that for England and Wales, but the total increase in population of 2,100 was made up of a natural increase of 323 accompanied by an immigration of 1,777. This is most likely to be explained by an increase in the number of Army and Air Force men in the district with an accompanying increase in their families.

Births :

The Birth Rate for Andover Rural District for 1952 showed a decrease below that for 1951, and whereas in 1951 it had been slightly above that for England and Wales, in 1952 it was below that for England and Wales. No doubt part at any rate of the explanation is the large proportion of unmarried Servicemen among the 1,777 immigrants.

Deaths :

The Death Rate for Andover Rural District for 1952 showed a decrease below that for 1951. In both years the Death Rate was below that for England and Wales. Here again, no doubt part at any rate of the explanation is the large proportion of young Servicemen among the 1,777 immigrants.

Infant Mortality :

The Infant Mortality Rate for a relatively small population such as Andover Rural District can be expected to vary widely from year to year, and no significance need be attached to the decrease in the rate between 1951 and 1952, which only represents a decrease from ten deaths to two. At the same time however, it does appear that the average infant mortality in Andover Rural District is lower than that in England and Wales, and the Infant Mortality Rate is the most important indication of the health of the community.

NATIONAL ASSISTANCE ACT, 1948

Section 47. Removal to suitable premises of persons in need of care and attention.

No action has been taken by the Council under this Section.

FOOD POISONING OUTBREAKS

No outbreaks of Food Poisoning occurred during 1952.

CLEAN FOOD CAMPAIGNS

The Film Shows and Discussions on Health Education including Clean Food, which had been offered hitherto to a number of existing organisations and given to those that accepted the offer, had to be discontinued when a charge for the screening of films by the Central Office of Information was introduced in June. A most valuable service which was highly appreciated by the Medical Officer of Health and by those who enjoyed it, was thus a victim of the present Government's economy drive.

Live Births	Male	Female	Total
Legitimate	137 (156)	144 (134)	281 (290)
Illegitimate ..	5 (8)	8 (3)	13 (11)
Total	142 (164)	152 (137)	294 (301)

Still Births	Male	Female	Total
Legitimate	5 (2)	3 (5)	8 (7)
Illegitimate ..	1 (0)	1 (0)	2 (0)
Total	6 (2)	4 (5)	10 (7)

Deaths of Infants under 1 year of age	Male	Female	Total
Legitimate	2 (9)	0 (1)	2 (10)
Illegitimate ..	0 (0)	0 (0)	0 (0)
Total	2 (9)	0 (1)	2 (10)

Deaths of Infants under 4 weeks of age	Male	Female	Total
Legitimate	2 (6)	0 (1)	2 (7)
Illegitimate ..	0 (0)	0 (0)	0 (0)
Total	2 (6)	0 (1)	2 (7)

Deaths	Male	Female	Total
Tuberculosis, respiratory ..	0 (1)	0 (1)	0 (2)
Tuberculosis, other	0 (1)	0 (0)	0 (1)
Syphilitic disease	0 (0)	0 (0)	0 (0)

	Male	Female	Total
Diphtheria	0 (0)	0 (0)	0 (0)
Whooping cough	1 (0)	0 (0)	1 (0)
Meningococcal infections	0 (0)	0 (0)	0 (0)
Acute poliomyelitis	0 (1)	0 (0)	0 (1)
Measles	0 (0)	0 (0)	0 (0)
Other infective and parasitic diseases	1 (1)	0 (0)	1 (1)
Malignant neoplasm, stomach	3 (2)	0 (3)	3 (5)
Malignant neoplasm, lung, bronchus	4 (5)	1 (1)	5 (6)
Malignant neoplasm, breast	0 (0)	2 (0)	2 (0)
Malignant neoplasm, uterus	0 (0)	1 (1)	1 (1)
Other malignant and lymphatic neoplasms	8 (7)	6 (3)	14 (10)
Leukaemia, aleukaemia	1 (3)	0 (1)	1 (4)
Diabetes	0 (1)	0 (1)	0 (2)
Vascular lesions of nervous system	5 (7)	15 (9)	20 (16)
Coronary disease, angina	15 (11)	4 (3)	19 (14)
Hypertension with heart disease	0 (0)	4 (3)	4 (3)
Other heart disease	11 (13)	9 (11)	20 (24)
Other circulatory disease	1 (0)	3 (0)	4 (0)
Influenza	0 (0)	0 (0)	0 (0)
Pneumonia	2 (4)	0 (4)	2 (8)
Bronchitis	3 (8)	2 (2)	5 (10)
Other diseases of respiratory system	0 (1)	1 (1)	1 (2)
Ulcer of stomach and duodenum	1 (0)	0 (0)	1 (0)
Gastritis, enteritis and diarrhoea	0 (0)	1 (1)	1 (1)
Nephritis and nephrosis	2 (2)	1 (0)	3 (2)
Hyperplasia of prostate	1 (0)	0 (0)	1 (0)
Pregnancy, childbirth, abortion	0 (0)	0 (0)	0 (0)
Congenital malformations	1 (0)	0 (1)	1 (1)
Other defined and ill-defined diseases	3 (13)	10 (7)	13 (20)
Motor vehicle accidents	2 (4)	0 (0)	2 (4)
All other accidents	1 (1)	2 (2)	3 (3)
Suicide	1 (0)	0 (1)	1 (1)
Homicide and operations of war	1 (0)	0 (0)	1 (0)
All causes	68 (86)	62 (56)	130 (142)

FOOD AND HEALTH

In the Annual Report of the Chief Medical Officer of the Ministry of Health for the year 1951, it is stated that 68,446 persons died from vascular lesions of the nervous system, as compared with 64,703 in 1950, that 58,309 persons died from coronary disease and angina, as compared with 54,755 in 1950 (this is described as an alarming and perplexing increase), that

5,630 persons died from ulcer of stomach and duodenum, as compared with 5,100 in 1950, that 3,703 persons died from diabetes as compared with 3,684 in 1950, and that 1,927 persons died from leukaemia and aleukaemia, as compared with 1,832 in 1950. In 1951 thirteen times as many schoolchildren died of cancer (207) as of diphtheria (16).* At the beginning of the century, many countries showed less than 5% of all deaths attributable to cancer and malignant tumours. By 1947 in great contrast, most of the nations studied had one in seven to nine deaths reported as due to cancer, with the percentage exceeding 10% in many cases.† The diseases mentioned above can all be described under the broad classification of degenerations of tissue. Our tissues are made up of the food we eat, and the presumption is therefore that there is something wrong with that food.

Cancer of the breast is ten times as frequent in England and America as in Japan. Cancer of all types is much commoner in London than elsewhere in this country, comparing especially unfavourably with rural areas. In Switzerland the death rate for cancer is 1,629 per million, but in Ceylon it is only 900, and of this, 800 is attributed to the local habit of betel-chewing, and cancer of the stomach is rare.‡ Primitive communities from four continents have been found to be almost completely free from hypertension, for instance, the blood pressure remaining stationary or falling with advancing age.|| The inference is that it is something in civilized diet which is responsible for the increase in degenerative disease, and it is hard to avoid the conclusion that the explanation is that our diet is becoming increasingly processed, sophisticated and adulterated.

Recently, the city analyst of Birmingham found that samples of meringue mixture were composed of methyl cellulose, an artificial product which is made from cotton and which has a superficial resemblance to white of egg, but which has no food value. He also found that meringue powder was compounded of an allied substance ethyl methyl cellulose, together with potato starch. The Ministry of Food had been consulted about and had approved the composition, description and labelling of these products. An example is given of beans obtained from a reputable store, which when placed in warm water refused to germinate and began to give off a strange odour. Upon enquiry at the store, it was found that these articles had been treated with some kind of preservative at the place abroad from which they had been imported. Experiments have been made in the use of an antibiotic (subtilin) as a food preservative. Grave dangers might arise from the use of antibiotics for such purposes. Some of them may be toxic. Continuous use may interfere with beneficial intestinal bacteria. The ingestion of them may create strains of resistent bacteria, and interfere with their therapeutic efficiency. Certain chemicals are used for destroying weeds, and are alleged to be selective in that they destroy the weeds but not the food plant which is growing in the field. The question is, what residues are left in the plant ? Recently, certain chemicals have been introduced in animal husbandry. An example of this is the extensive use in the United States and to some extent in this country, of the implantation into chickens of an artificial hormone known as stilboestrol. The effect of this substance is to interfere with normal sexual development in a manner somewhat similar to that resulting from the older process for producing capons. A larger quantity than usual of fat is deposited under the skin and the appearance of the fowl to the consumer is improved, although it is alleged that the quality of the meat and of the fat is interfered with. What effect this may produce upon consumers is difficult to say. The substance is supposed to be implanted in the neck of the chicken which is not normally used for human consumption. An interesting sidelight is thrown upon this by the fact that in the United States the discarded heads and necks were under the advice of the Department of Agriculture, sold to mink farmers for feeding their animals with the result that the mink became infertile and were unable to reproduce. The loss was so serious that a Bill was passed through Congress to compensate the mink farmers. The above examples are taken from a paper given by Lord Douglas at a sessional meeting which I attended of the Royal Sanitary Institute.

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* " Medical Officer," 1953, I, 36.
† " Public Health," 1951–52, 196.
‡ " Medical Officer," 1952, II, 64.
|| British Medical Journal, 1953, I, 1320.

It may be that our diet is responsible for more than an increase in the death rate from degenerative diseases. A recent survey* of sick absence in the Metropolitan police disclosed that the rate of sick absence was considerably higher post war than prewar, being 4.67% in 1951 compared to 2.66% in 1938. During the post war years under investigation there was a 52% average increase in the number of sick absence spells per man compared to prewar. Younger policemen showed the most increase in frequency of sickness. The average length of sick leave increased by 16%. The rate of sick absence increased in men under 50 by about 70% and in older men by about 40%.

In this country the Ministries responsible for our food are those of Food and of Agriculture and Fisheries. Now the objectives of these two Ministries must be to produce as much food as possible and food which the consumer finds acceptable, and these objectives must conflict with that of the effect of food on health. It would be much better if the responsibility for all questions involving the addition of unnatural chemicals to food rested with the Ministry of Health. Practice in the United States is much ahead of that in this country. There is in the United States a large and important department called the Food and Drugs Administration which is responsible for this question of the addition of chemicals to food, and this provides the explanation for progress there. In this country, the only organisation is the toxicological research unit of the Medical Research Council, but its objectives are quite different and much more limited. The position is that we are in the undignified position of having to rely on the decisions arrived at in the United States before policy or action can be determined here. It is not as if the questions at issue were small and of rare occurrence. Questions of great public interest are constantly coming up, and the Food and Drugs Administration is very active. The establishment of a similar department in this country is long overdue.

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* Monthly Bulletin of the Ministry of Health, 1953, 42.

There is more however to this question of food than ensuring that it is fresh, natural and wholesome, and has not been so treated as to do harm. There is also the matter of how it has been grown. An examination of the work in India of Sir Albert Howard* proves that disease and pests in plants and crops grown in their proper climate can be entirely eradicated by ensuring that the soil upon which they are reared receives adequate supplies of organic material in the form of plant and animal waste. He went further and demonstrated that the eradication of disease in cattle and livestock was a practicable possibility when these are reared and nurtured on land and on crops which have been organically treated in the same way. He actually allowed, on repeated occasions, his own cattle to rub noses with cattle in neighbouring fields suffering from foot and mouth disease, and on no occasion did his cattle take the disease. There is a body of farmers today in this country who have proved that if they maintain their land in first class condition by organic means, they are enabled to remain entirely immune to diseased crops, and to such scourges as foot and mouth disease, tuberculosis, contagious abortion and fowl pest, all of which are indices of bad husbandry of the land.

The work of another great man, Sir Robert McCarrison,† again in India, is very relevant to this subject. He noted the Hunza tribe, which he gave as an example of splendid positive health. He observed that they and the Sikhs were long-lived, vigorous in youth and age, capable of great endurance, and enjoying a remarkable freedom from disease in general. They were moreover possessed of a cheerful countenance. He further observed that they lived very close to the land and obeyed nature's law of returning to their soil every vestige of organic waste matter. He noted in startling contrast, the Madrassis of the South, who were disease-ridden and of poor physique, with a depressed and quarrelsome outlook on life. McCarrison set to work with colonies of rats and fed one colony on the Sikh diet of fresh wholemeal cereal grain, dairy produce, eggs, pulses and a little meat, and another separate colony on the Madrassi diet of white bread, margarine, white sugar, jam and meat. The rats on the Sikh diet remained in excellent health, with healthy coats and immunity to disease, and lived happily together, while the rats on the Madrassi diet were stunted in growth, had poor coats, were subject to such diseases as duodenal ulcers, respiratory catarrhs and miscarriages, and were quarrelsome to the extent of cannibalism. McCarrison subsequently fed further colonies of rats on diets typical of many of the various races in India and experienced in each such colony the same diseases as were prevalent in those races, and in total practically every major disease experienced in mankind.

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* Howard A (1945) Farming and Gardening for Health or Disease.

† McCarrison R (1944) Nutrition and National Health.

SMOKING AND CANCER OF THE LUNG

The statistical investigation of the relationship between smoking and cancer of the lung on which I reported in my last two annual reports, has been followed by a further one* by the same authors, covering many parts of the country (the earlier one was confined to London, and the adjacent counties) and involving more detailed inquiries into smoking habits, and some extracts from this investigation, which confirmed the earlier one, are given hereunder. Whereas among a control group of 1,357 men and 108 women without cancer of the lung 61 (4.5%) of the men and 59 (54.6%) of the women were non-smokers, among a group of 1,357 men and 108 women with cancer of the lung only 7 (0.5%) of the men and 40 (37.0%) of the women were non-smokers. Whereas among the control group only 166 (12.2%) of the men and 0 (0.0%) of the women, had smoked 25 or more cigarettes a day over the preceding 10 years, among the group with cancer of the lung 331 (24.4%) of the men and 14 (13.0%) of the women had done so. It was calculated that above the age of 45 the risk of cancer of the lung was 21 times as great among men and 13 times as great among women who had smoked 25 or more cigarettes a day over the preceding 10 years as among non-smokers. A similar survey of smoking habits of doctors dying from cancer of the lung and from other cancers is quoted in the British Medical Journal.† In the lung cancer group only 5.8% smoked on average less than 15 cigarettes or their equivalent a day, as compared with 43.4% in the other cancer group. As regards the heavy smokers, in the lung cancer group 33.8% smoked on average 35 or more cigarettes or their equivalent a day as compared with only 12.7% in the other cancer group. In a letter in the British Medical Journal* it is stated that whereas the chances of dying of cancer of the lung before 55 are 1 in 1000 for a non-smoker, they are 1 in 70 for a person who smokes 15–25 cigarettes a day and 1 in 50 for one who smokes 25–50.

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* British Medical Journal, 1952, II, 1271.

† British Medical Journal, 1953, I, 986.

The actual figures for deaths from cancer of the lung in England and Wales are no less startling.† Whereas in 1931, 1,635 men and 651 women (total 2,286) died of cancer of the lung, in 1951, 11,166 men and 2,081 women (total 13,247) died of cancer of the lung. Whereas in 1931, cancer of the lung represented 6% of all cancer in men and 2% in women, in 1951, it represented 25% of all cancer in men and 5% of all cancer in women. In a letter in the British Medical Journal‡ it is suggested that correlating the rising curve of tobacco consumption with that of deaths from lung cancer over the last 25 years, the annual increase of approximately 1,000 deaths will continue until 1965 by which time nearly 25,000 people will die each year.

It has been suggested that the increase in cancer of the lung is due to improved diagnosis. But it is pointed out† that the number of cases is still increasing by about 1000 per year although it is most unlikely that improved diagnosis could account for this, that mortality in males has increased by 3 times and in females by 2 times since 1931, although diagnostic facilities are equal for both sexes, that considerable differences exist in the death rates of towns which have similar diagnostic facilities, and that professional workers, including doctors, give rates rather below the average although here the availability of diagnostic facilities would presumably be at a maximum.

Air pollution has been suggested as a cause, but rates in cities are never more than twice as high as in the country** (which could be explained by the heavier smoking of city dwellers) whereas as indicated above, rates for smokers are more than 20 times as high as for non-smokers. Cancer of the lung does occur occasionally in non-smokers, and it is suggested therefore that smoking cannot be the cause of cancer of the lung, but whereas the cancer which occurs in smokers in a squamous carcinoma, that which occurs in non-smokers is an adenocarcinoma.† This point was also made by Mr. F. E. Chin, Thoracic Surgeon, Thoracic Surgical Unit, Southampton Chest Hospital, at a meeting which I attended of the Southern Branch of the Society of Medical Officers of Health.

Meanwhile Mr. Iain MacLeod (Minister of Health), says that he is not aware of any generally accepted cause or causes of the increase in the number of cases of cancer of the lung, and Miss Pat Hornsby-Smith (Parliamentary Under-Secretary, Ministry of Health) says that she accepts the statistical relationship between smoking and cancer of the lung, but not that it is causal, though how she can do this, I cannot understand. If it is statistically significant it is not coincidental, it is impossible that cancer of the lung could cause smoking, and although the possibility that both could be due to a third factor seems at first sight attractive, the longer one thinks about it the less likely this appears.

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* British Medical Journal, 1953, I, 1105.

† Annual Report of the Chief Medical Officer of the Ministry of Health, for the year 1951.

‡ British Medical Journal, 1953, I, 161.

** British Medical Journal, 1952, II, 982.

SECTION B.

GENERAL PROVISION OF HEALTH SERVICES FOR THE AREA

NATIONAL HEALTH SERVICE ACT, 1946

LOCAL HEALTH SERVICES UNDER PART III

In paragraph 20 of Ministry of Health circular 118/47, it was recommended that all counties should be sub-divided according to local health requirements, that in each Sub-Division the County Health Committee would use its powers under paragraphs 6 and 7 of Part II of the Fourth Schedule to the Act to appoint a Sub-Committee on which the Councils of County Districts comprising the Sub-Division would be represented, and to which would be delegated the day to day administration in the Division of the Part III (Local Health Authority) Services of the National Health Service Act, and that under the County Medical Officer, executive charge of these Services in the Division would be taken either by an existing Assistant County Medical Officer, preferably one who was also Medical Officer of Health of one or more of the districts constituting the Division, or by the Medical Officer of Health of one of these Districts who would be appointed to the staff of the County Medical Officer. The County Council as the Local Health Authority would of course retain its responsibility for policy and finance unimpaired, but to day to day administration the Sub-Committee would bring the local interest and knowledge which are so desirable in such personal services.

In paragraph 7 of Ministry of Health circular 27/51 county councils were again recommended to have regard to the advantages which might be expected to flow from a plan, which besides providing for a single officer to hold the office of Medical Officer of Health for two or more county districts where this was appropriate, also provided for him to be employed part-time in county council services and so to help to administer the personal health services of the county council in the area in addition to discharging the duties which fell to him as County District Medical Officer of Health. The Minister was sure that such arrangements were in the interests of the local services as well as of the officers themselves, because they secured to those services the help of Medical Officers experienced in the administration of both kinds of local health services—environmental and personal. The marked growth in recent years of arrangements of this kind was itself sufficient testimony of their value and practicability.

The Minister of Health at the Annual Dinner of the Society of Medical Officers of Health on 23rd October, 1952, said,

" But I am perhaps less happy in my mind about the relationship of local authorities and local people to the Health Service than any other aspect of it. Here we have a number of problems not only unsolved, but completely untouched. There is the problem for example whether the personal health services should or should not be managed one tier down from where they are at present administered."

The recommendations of the Delegation Sub-Committee of the Local Government Manpower Committee which were published by the Committee and which were endorsed by the then Minister of Local Government and Planning, included recommendations similar to those of Ministry of Health circular 118/47 (Local Government Manpower Committee, Second Report, Appendix X, Section G, Health.)

A memorandum agreed by the Council of the Society of Medical Officers of Health, which was published by the Society, stated that the Society of Medical Officers of Health was in favour of decentralisation of National Health Service Part III Functions by county councils wherever practicable, that the Society considered that such decentralisation should be to Sub-Committees of County Health Committees (as authorised by the Fourth Schedule Part II, paragraphs 6 and 7), which should be responsible for day to day administration of some or all of the Part III Services, that the Medical Officer appointed to serve the Sub-Committee normally had other duties to perform and might be Medical Officer of Health for one or more of the county districts in the area, that so far as the Medical Officer's duties under Part III of the National Health Service were concerned he acted as a senior member of the staff of the County Medical Officer, and that policy, finance and establishment were retained as functions of the central committee.

In paragraph 28 of the Minutes of Report No. 7/1952 of the Health Committee of the Association of Municipal Corporations, the Association, in commenting on the Memorandum of the Society of Medical Officers of Health, stated that they had always been opposed to the transfer of maternity and child welfare and other local health functions from the councils of county districts to county councils under Part III of the National Health Service Act 1946, as these services were regarded as being of such a personal and intimate nature that they should be dealt with by local authorities in the closest contact with the persons for whom the service was provided, and that as no provision was made for the direct delegation of functions to county district councils the Association favoured the implementation of the recommendations of the Delegation Sub-Committee of the Local Government Manpower Committee to the fullest extent until such time as amending legislation was passed to place the service on a more satisfactory basis.

In a Study on "Autonomy and Delegation in County Government, Delegation in Education and Local Health Administration," prepared for the Institute of Public Administration, by Miss Emmeline Cohen, it was stated (page 62 paragraph 2)—"In the West Riding the area officer, who is also M.O.H., is looked upon as a social worker par excellence, seeking to strike at the root of disease by changing the living conditions of the people. To attend a local conference is to see this concept take shape in an impressive way. The area officer, sanitary inspector, senior health visitor, senior home-nurse and T.B. welfare visitor between them know intimately the streets and the people in them and can pinpoint problems relating to families or conditions and bring cohesion into local policy. The officer in a division so organised is the captain of a team and the team is a coherent unit in the county's health organisation. At a conference of this kind, questions of liaison with other parts of the service come up and those incapable of local solution are referred to the county council." Further favourable comment on the working out in practice of what Miss Cohen calls a new local focus in local health administration can be found on pages 64 paragraph 3, and 78 paragraph 3.

A large proportion of the counties in England and Wales have carried out the recommendation of the Minister of Health on formation of divisions with Divisional Medical Officers, including two counties as dissimilar as the West Riding with 31 Divisions of an average population of 51,251 at the 1951 census and 31 Divisional Medical Officers, and Cornwall with 7 areas of an average population of 49,373 at the 1951 census and 7 Area Medical Officers, but no such sub-division has taken place in Hampshire. Charge of duties under Section 26 (Vaccination and Immunisation) is taken by the Medical Officer of Health but charge of duties under Sections 22 (Care of Mothers and Young Children) 23 (Midwives) 24 (Health Visitors) 25 (Home Nursing) 27 (Ambulances) 28 (Prevention of Illness, Care and After Care) and 29 (Domestic Help) remains with the County Medical Officer. The District Health Sub-Committee has advisory functions only in connection with these Sections with the exception of Section 27 (Ambulances), but the officers carrying out these services come directly under the control of the County Health Committee and are in no way answerable to the District Health Sub-Committee.

The area of the three Councils for which I am Medical Officer of Health is admirably suited for a scheme of divisional administration. Its population was 50,050 at the 1951 census which is similar to that which has been found appropriate in other counties. The northern and western boundaries of the area are formed by the Berkshire and Wiltshire County Boundaries and so cannot be altered, and the area forms a natural geographical unit of the kind most appropriate outside the major conurbations for the administration of these particular services.

Following the receipt of Ministry of Health circular 27/51, discussions were held between the three Councils, and at a meeting of representatives of the three Councils held on 20th March, 1952, a resolution in favour of divisional administration was passed unanimously, which resolution was subsequently adopted by each of the three Councils and by the two District Health Sub-Committees of the County Council covering the area of the three Councils. A deputation from the three Councils was received by a sub-committee of the County Council's Health Committee on 18th September, 1952, but the County Council refused to consider the scheme put forward. The three Councils then approached the Ministry of Health and a meeting between the interested parties took place at the Ministry on 24th March, 1953, at which meeting, the County Council representatives having accepted the principle of decentralised administration contained in paragraph 20 of Ministry of Health circular 118/47, it was agreed that further discussions should take place between the three Councils and the County Council. The three Councils then prepared a draft scheme on the basis of paragraph 20 of circular 118/47 for discussion with the County Council, but the County Council have refused to discuss it. There the matter rests, except that on the day the County Council's refusal was received, your Medical Officer of Health submitted his resignation to the three Councils on being appointed a Divisional Medical Health Officer under the Nova Scotia Provincial Government. It must not be supposed, and I do not think it likely to be supposed, that the coincidence of events was fortuitous.

SECTION 26 (VACCINATION AND IMMUNISATION)

This is therefore the only one of the Part III (Local Health Authority) Services under the National Health Service Act on which I am able to report.

Notification of birth cards received by the County Medical Officer from the Health Visitors are sent to the Medical Officer of Health, who prepares Diphtheria Immunisation Record Cards from them, and these form a Diphtheria Immunisation Card Index. Consent cards received by parents from the Health Visitors are sent to the Medical Officer of Health who sends the corresponding Diphtheria Immunisation Record Cards to the general practitioners, and they perform the immunisation. A Diphtheria Immunisation Clinic is also conducted by the Medical Officer of Health with the assistance of the Health Visitors at the Health Centre, Junction Road, Andover, at 11 a.m. on the first Saturday in the month for those children whose parents wish them to be immunised by him.

DIPHTHERIA IMMUNISATION

Annual Return for year ended 31st December, 1952

A. Number of children who completed a full course of primary immunisation in the authority's area (including temporary residents) during the year ended 31st December, 1952.

Age at date of final injection (as regards A)

Under 1	1	2	3	4	5 to 9	10 to 14	Total
14	138	54	7	10			223

B. Number of children who received a secondary (reinforcing) injection (i.e. subsequently to primary immunisation at an earlier age) during the year ended 31st December, 1952.

Age at date of reinforcing injection (as regards B)

Under 1	1	2	3	4	5 to 9	10 to 14	Total
					385	141	526

The figures of 526 for total number of children who were given a secondary (reinforcing) injection (i.e. subsequently to primary immunisation at an earlier age), compare with 279 for the previous year, and are the result of the continuation and modification of a campaign to improve the state of immunity of the school children.

A letter was prepared by the Medical Officer of Health giving details of the advisability of primary and reinforcing immunisation, and requesting return of an attached consent form giving details of who it was desired should carry out the immunisation, and of the child's immunisation state. Copies of this letter were sent to the Head Teachers of all Primary Schools for distribution to children aged 5 and 10. Consent forms completed by the parents were returned by the Head Teachers to the Medical Officer of Health and were examined to see whether the child required reinforcing immunisation. In the previous year, where the parent had requested that the Medical Officer of Health should carry out the immunisation, Diphtheria Immunisation Reinforcing Injections Record Sheets were prepared and sent to the general practitioners, who were asked to carry out the immunisations at the schools on behalf of the Medical Officer of Health, with payment on a sessional basis, the schools being allocated among them proportionately and with regard to the area of their practice. Unfortunately however some of the general practitioners were unable to carry out the immunisations before the end of the year, and it was feared that the Diphtheria Immunisation Reinforcing Injections Record Sheets might have become out of date due to children moving on to the Secondary Schools, or leaving the district, and that children who should have been immunised might have been missed. This year therefore, Diphtheria Immunisation Sessions at Schools were conducted by the Medical Officer of Health with the assistance of the Health Visitors. Where the parent had requested that the general practitioner should carry out the immunisation, Diphtheria Immunisation Record Cards or Diphtheria Immunisation Reinforcing Injections Record Sheets were prepared and sent to the general practitioner, with payment on a per capita or sessional basis respectively, depending on the number to be immunised. Arrangements for all sessions were made by the Medical Officer of Health. This has worked very well.

Immunisation in Relation to Child Population

Number of children at 31st December, 1952, who had completed a course of immunisation at any time before that date (i.e. at any time since 1st January, 1938).

Age at 31st December, 1952:	Under 1	1	2	3	4	5 to 9	10 to 14	Total
i.e. born in year:	1952	1951	1950	1949	1948	1943-47	1938-42	Un'r 15
Number immunised:	19	157	319	212	268	520	24	1519

Diphtheria Notifications and Deaths in Relation to Immunisation during the year 1952

NIL.

I regret that I am not able this year to include the information about the percentages who have been immunised of the various age groups of children in this district as compared with the County as a whole, which information has been contained in previous reports, as the Registrar General has ceased supplying the figures for numbers of children in the various age groups in the district, on which figures estimation of these percentages depends. In his letter giving this information the Registrar General states that figures for Counties will continue to be supplied, and that Medical Officers of Health should be able to derive an estimate of these percentages from local infant welfare or school medical records or by special surveys of sections of the child population, and both these points are worthy of some comment.

As regards the statement that figures for Counties will continue to be supplied, it is the case that vaccination and immunisation was the only part of the Personal Health Services which was carried out by all County Districts before the passing of the National Health Service Act, although other parts were carried out by some County Districts, and it is the one part of the Personal Health Services which is still devolved to County Districts by Counties to any extent over the country generally. Accordingly variations in the degree of success achieved in carrying out these duties are between one County District and another, rather than between one County and another, and it would be of much more value to Medical Officers of Health to have the figures which would enable them to compare County District with County District rather than to have only those which enable them to compare County with County.

As regards the suggestion that Medical Officers of Health should be able to derive an estimate of these percentages in one or other of a number of different ways it is precisely because different Medical Officers of Health are likely to use different ways in their efforts to arrive at these percentages, and because even when they use the same way their methods will vary as will local circumstances that figures for different County Districts, while they may be of some value to the Medical Officers of Health. of each County District alone, will be of little value as a basis of comparison between County Districts. It is extremely doubtful whether the effort involved in making these estimates will really be worth while.

There is however another wider issue involved, on which I should also like to comment. This is at least the third blow in the last three years to the position of the Medical Officer of Health Other Medical Officers of Health may recall other examples, but it is not out of place to mention the two which come most readily to mind in addition to the example quoted above.

Last year the Minister of Health announced that it would no longer be necessary for Medical Officers of Health to keep a Tuberculosis Register, although it was hoped that they would still do so. Expressed in other words this seems to mean that Medical Officers of Health will still be expected to keep a Tuberculosis Register, although they will no longer get credit for doing so. This Medical Officer of Health at any rate continues to keep a Tuberculosis Register, so long as he is permitted to, as he regards it as an essential part of his duty to the community, if not to the Minister of Health.

The previous year the Minister of Health announced that leprosy was to be notifiable not to the Medical Officer of Health, but to the Minister. Leprosy of course is not common in this country, although there have been two recent cases in Wiltshire, but it is the reason given for this action that is so remarkable. Apparently this procedure is in the interests of secrecy. Medical Officers of Health, it seems, cannot be trusted to keep such information to themselves.

This Medical Officer of Health at any rate finds it hard to avoid the suspicion that consciously or unconsciously a policy is under way which will ultimately cut him off from all his sources of information as a guardian of the Public Health without, so far as can be seen, putting anything else in his place.

SOME THOUGHTS ON DIPHTHERIA IMMUNISATION

Last year I included some words on the Decline in Diphtheria Immunisation which in general was consequent on an unjustified scare about the connection between immunisation and subsequent poliomyelitis in the inoculated limb, but which in particular appeared from figures which I quoted to have been due to a large decline in the immunisations carried out by Local Authorities, with at the same time no decline in the immunisations carried out by general practitioners. This reverse appears now to have been restored, as the figure for the first half of 1952, 287,000, compares favourably with those for the whole of 1951 and 1950, 497,000 and 433,000, and is in strict agreement with that for the whole of 1949, 574,000. The figure for the whole of 1952 is not yet available, as the Minister of Health issued his information for the annual propaganda campaigns two months earlier this year, presumably in the hope of getting such campaigns over by the middle of the year as if the connection between immunisation and poliomyelitis is of any importance, it has been shown* that the incidence of poliomyelitis rises from a minimum at the beginning of July to a maximum at the end of September and falls again to a minimum at the end of December.

The emphasis in this year's campaign appears to be more on getting children immunised early, now that the number of children immunised has been restored, and some comments on this topic are therefore not out of place. Hitherto the consensus of opinion has been that the presence in the infant's body of antitoxin derived from the mother made it inadvisable to immunise in the first six or eight months of life, and as many mothers had lost touch with child welfare centre or general practitioner by that time, it became more difficult to bring the children in for immunisation and more were lost altogether. There seems now to be less emphasis on this factor and immunisation as early as three† or even two‡** months is now being suggested. It is emphasised that younger children are relatively less liable to reactions following immunisation than older children†, and that the dose can therefore be correspondingly larger, and that in particular a dose of 0.5 c.c. was likely to be sufficient to overcome the maternal antitoxin† to which dose objections on the score of possible reactions were ill-founded. A further point made was** that the incidence of poliomyelitis was less in the first months of life than later and that here was a further argument for earlier immunisation.

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* Monthly Bulletin of the Ministry of Health and the Public Health Laboratory Service, 1953, 2.

† British Medical Journal, 1952, II, 1011.

‡ British Medical Journal, 1952, II, 1012.

** Information Digest, 1952, II, 54.

Two interesting points arise from this discussion. In the first place, if the child can be immunised while the mother is still bringing it to the child welfare centre or general practitioner, it will be easier to bring it in for immunisation and fewer children will be lost altogether. In the second place the possibility of combining diphtheria immunisation with whooping cough immunisation becomes much greater. Whooping cough is essentially a great killer in early infancy and the chief argument against combining the two prophylactics has been that the correct date for whooping cough immunisation was too early for diphtheria immunisation, and the correct date for diphtheria immunisation was too late for whooping cough immunisation. It has been stated* that the combination of several antigens in mixed vaccines produces immunity titres greater than those which can be obtained by separate inoculation of each antigen and that here is a further argument for combined immunisation.

On the subject of immunisation against a number of different infectious diseases, it might be held that the chief limiting factor is the patience and co-operation of the average mother. Many people would say that it was unreasonable to expect her to take steps to have her child protected against more than three different diseases, and that if this was the case, thought would have to be given to deciding which three were the most important. Many Medical Officers of Health still lament that vaccination against smallpox is not still compulsory (although voluntary immunisation against diphtheria, because of the greater importance of the latter to the community, is far more successful than compulsory vaccination against smallpox ever was) but if it is accepted that protection against three infections is all that can be asked for, surely diphtheria, whooping cough and tuberculosis have a prior claim over smallpox, particularly when it is remembered that the evidence is that it is general public health measures that are responsible for the control of smallpox, and not vaccination, which in the face of an outbreak serves mainly to cloud the issue.

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* Information Digest, 1952, II, 55.

SECTION F

Prevalence of and Control over Infectious and other Diseases

Final numbers according to Sex and Age after Corrections of Cases of Infectious and other Notifiable Diseases notified during the year ended 31st December, 1952.

	Scarlet Fever			Whooping Cough			Acute poliomyelitis Paralytic			Acute poliomyelitis Non-Paralytic			Measles		
	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T
Under 1 year															
1–2 years				1	4	5							1		1
3–4 years				1	2	3							2	1	3
5–9 years	1	1	2	6	5	11	1		1				1	1	2
10–14 years														1	1
15–24 years	1	1	2										2	1	3
25 and over					2	2									
Age unknown															
Total (All ages)	2	2	4	8	13	21	1		1				6	4	10

	Acute Pneumonia		
	M	F	T
Under 5 years			
5–14 years			
15–44 years	1		1
45–64 years	1		1
65 and over			
Age unknown			
Total (All ages)	2		2

INFECTIOUS DISEASES

The one case of poliomyelitis occured in a male aged 5 months on 19th October, in Amport. There were three cases in males aged 7, 13 and 20 on 8th, 16th and 21st August, in Croye Close, South Street and Old Winton Road, Andover, in other words the cases were separated in time and place and had no obvious contact with one another. I have no doubt that from August to October, there was a high carrier rate for poliomyelitis and also that there was a large number of sub-clinical cases in addition to the one clinical case. The child was slightly paralysed.

Once again I would like to draw attention to the importance of whooping cough as a cause of death in young children, especially infants, and to the practicability of action to put an end to this situation. Within the last year the predominance of whooping cough among the infections of childhood has become more widely appreciated and I propose to quote one or two extracts on the subject. Since 1946 deaths from whooping cough have exceeded those from smallpox, scarlet fever, measles and diphtheria added together, and as a cause of infant deaths from infection it comes after the two rather ill-defined groups of bronchitis-pneumonia and diarrhoea-enteritis*. In 1950 whooping cough was responsible for as many infant deaths as measles, scarlet fever, diphtheria, poliomyelitis, encephalitis and meningococcal infections combined. At present, amongst communicable conditions it comes only after the heterogenous groups of bronchitis-pneumonia and diarrhoea-enteritis as a cause of death in infants†. In comparison with measles and scarlet fever—the latter once a notorious killer—whooping cough presents a case fatality rate which is about five times that of the other diseases‡. The actual case fatality rates for measles, scarlet fever and whooping cough for 1951 were 0.05%, 0.08% and 0.27%, so that for 1951, the case fatality rate for whooping cough was three times that for scarlet fever and five times that for measles**. Whooping cough is not only the chief killer among the childhood infections, it is also responsible for much later ill health. Mr. E. F. Chin, Thoracic Surgeon, Thoracic Surgical Unit, Southampton Chest Hospital, speaking at a meeting which I attended of the Southern Branch of the Society of Medical Officers of Health, said that in 80% of cases of bronchiectasis (lung abscess) there was a definite history of chronic productive cough after the onset of whooping cough, and stressed also the importance of the damage which was done when atelectasis (lung collapse) occurred during whooping cough. These two points have also been stressed by Dr. H. J. Parish††. Finally a follow-up of 39 children who had suffered from whooping cough disclosed that 9 had mental or physical defects, and that a further 6 had had marked cerebral symptoms while in hospital‡‡.

Whooping cough therefore stands out above all others and I repeat once more some figures from a report on the statistical investigation of immunisation against the disease*. Over a two to three year period of observation 149 of the 3801 vaccinated children developed whooping cough, whereas 687 of the 3757 unvaccinated children developed whooping cough, giving attack rates per 1000 child months of 1.45 and 6.87 respectively, and a reduction in the disease of 78%. Among children exposed to whooping cough in their own homes the attack rates were 18.2% in the vaccinated and 87.3% in the unvaccinated groups. The cases that occurred in the vaccinated were on the average less severe and of shorter duration than those in the unvaccinated children. During the two to three year periods of observation there was no evidence of a waning in the degree of protection afforded by the vaccines. Five vaccines were tested of which much the most effective were two prepared by the Michigan Department of Health, although the other three were also of value. The attack rates in home exposures with the Michigan vaccines were only 7.3% and 8.9% (as against 87.3% in the unvaccinated groups) giving a reduction in the disease of 91.5%. The report on the further comparative investigations which as I have mentioned in my last two reports have been taking place, has not yet been published, but it is hoped that it will soon be possible to undertake a campaign similar to that already undertaken for diphtheria immunisation, and that the Public Health Service will be able to take the same part in the second campaign as it has done in the first. As I have mentioned in the section of my report dealing with Diphtheria Immunisation, the objections to early immunisation against diphtheria seem less strong than heretofore, early immunisation will ensure fewer children being missed, and the two vaccines produce a better immunity given together.

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* Monthly Bulletin of the Ministry of Health and the Public Health Laboratory Service, 1953, 12, 92.

† Monthly Bulletin of the Ministry of Health and the Public Health Laboratory Service, 1953, 12, 98.

‡ Information Digest, 1953, I, 104.

** Annual Report of the Chief Medical Officer of the Ministry of Health, for the year 1951.

†† British Medical Journal, 1952, II, 1011.

‡‡ Information Digest, 1953, I, 106.

TUBERCULOSIS

	New Cases						Deaths					
Age Periods	Respiratory			Non-Respiratory			Respiratory			Non-Respiratory		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
0—												
1—					1	1						
5—												
15—	1	3	4		1	1						
25—	1	3	4									
35—	3		3		1	1						
45—												
55—												
65 and upwards												
Total	5	6	11		3	3						

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* British Medical Journal, 1951, I, 1463.

Number of Cases on the Tuberculosis Register on 31st December, 1952

(31ST DECEMBER, 1951, IN BRACKETS)

	Male		Female		Total	
Respiratory	26	(24)	18	(16)	44	(40)
Non-Respiratory ..	3	(3)	5	(3)	8	(6)
Total	29	(27)	23	(19)	52	(46)

TUBERCULOSIS

During the year the number of cases on the Tuberculosis Register has increased by 6 as shown in the second table. There were 14 new cases and 0 deaths as shown in the first table, and the balance is made up by a further 8 cases which were removed from the Register as under :—

Recovered	2
Dead	0
Left district	6
Not found in district after adequate search ..	0
Total	8

The Bulletin of the National Association for the Prevention of Tuberculosis has been conducting a campaign in favour of B.C.G. (Bacille Calmette Guerin) vaccination against tuberculosis and I quote hereunder from relevant editorials.

" Britain tends to occupy a somewhat isolated position in the world campaign against tuberculosis. We are not esteemed very highly as regards prevention. Reading the literature from other countries about the use of B.C.G., no one can fail to be struck by the contrast with our British outlook. Other nations, as for instance the countries of Scandinavia, place B.C.G. in the forefront of their preventive work. We in Britain appear to use it half heartedly. Another important question arises : it is still unlawful to manufacture B.C.G. in this country. This vaccine is being made in at least ten European countries, in Canada, the U.S.A., India, Ceylon, Australia, Singapore, Indonesia, Turkey, China, three South American countries, and in the U.S.S.R., but apparently it cannot be manufactured here. Seemingly the shoulders of our Government are not broad enough to bear this responsibility*."

" The Ministry of Health speaks with two voices. One voice tells us we ought to have B.C.G. if we belong to one of three categories : the other tells us to wait until we can be sure whether it is desirable or not. Is this an attitude of scientific detachment, or is it merely an administrative compromise* ?"

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* N.A.P.T. Bulletin, 1952, 817.

Dr. F. C. S. Bradbury's contribution on " Should School Leavers have B.C.G. ?"†, is of particular value and represents the most clearly thought out and logical expression of opinion on this matter that I have seen. " A good test of the value of any form of treatment, whether curative or preventive is ' Would you apply it to your own family ?' In the case of B.C.G. I unhesitatingly answer ' Yes.' It is discouraging to find among the present eligible groups, so relatively few who qualify for B.C.G. by being tuberculin-negative. Believing B.C.G. to be a valuable weapon in our anti-tuberculosis campaign, I would like to see it made available to a much wider population. The problem of segregation adds to our present difficulties, but this would not arise with non-contact children. It is established that about 50% of school leavers are tuberculin positive. This seems to me a strong reason for not specifying school leavers as a group to whom the availability of B.C.G. should be extended. Why not throw it open to all children or if there must be a limit, why not choose the younger children ? As I believe from my own investigation that adult tuberculosis is a recrudescence of the primary lesion, I consider that every care should be taken of a child who is undergoing a primary infection. This will include measures to ensure that the child is prepared to deal with a primary infection and here B.C.G. occupies a high place. I would prefer to offer B.C.G. to the younger children. Apart from the medical aspect, the problem may become one of manpower and any large scale extension of B.C.G. to school children would no doubt require the co-operation of the School Medical Service."

Following the editorials in the October and December issues, the Bulletin has returned to the subject with further editorials in the February and April issues. " B.C.G. vaccine should be manufactured in Britain. B.C.G. should be available for use not only among the present categories, but more widely at the discretion of physicians. The vaccination of school-leavers—that age group approaching the years of most serious liability to tuberculosis—should be added at once to the list of officially permitted categories."‡ " Scandinavian visitors and others smile and tell us that in Britain treatment is everything and prevention is nothing. There seems to be no immediate hope of B.C.G. being manufactured in this country. The extraordinary situation is to be allowed to persist that we depend upon supplies from outside. The Medical Research Council trials of B.C.G.

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* N.A.P.T. Bulletin, 1952, 856.

† N.A.P.T. Bulletin, 1952, 857.

‡ N.A.P.T. Bulletin, 1953, 2.

and vole bacillus vaccine continue, and one day we may expect definite results. We wish this zeal for research were matched by a corresponding energy in preventive medicine."*

Meanwhile what does the Government say ? Answering a question in the House of Commons, Commander T. D. Galbraith (Parliamentary Under-Secretary Scottish Office), says it would cost several thousand pounds to manufacture B.C.G. here. I suppose he forgets it costs more than several million pounds to deal with the manifold consequences of pulmonary tuberculosis.

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* N.A.P.T. Bulletin, 1953, 37.

SECTION C

1. WATER SUPPLY

There have been no extensions of water mains during the year from sources within the area.

Chlorination of the Appleshaw, Faberstown and Vernham Dean supplies was continued as there was still intermittent evidence of slight pollution of the source.

Regular sampling for bacteriological examination of the piped supplies was maintained. Seven samples of the Vernham Dean supply and three of the Faberstown supply taken prior to chlorination were found to be slightly polluted.

In areas served by piped supplies, particulars of populations supplied are as follows :—

	No. of dwellings supplied from mains	No. of population supplied by standpipe
Appleshaw part Fyfield, Kimpton	170	58
Vernham Dean	88	23
Shipton Bellinger	202	—

South Tedworth, a War Department establishment, has its own supply.

Bacteriological Examination of all Water Supplies, private and public

Number of samples taken	260
Number of samples reported satisfactory	211
Number of samples reported not entirely satisfactory ..	13
Number of samples reported unsatisfactory	36

2. DRAINAGE AND SEWERAGE

Faberstown

During the year 35 of the 40 houses at Faberstown were connected to the main sewer.

No constructional work of main drainage in the district commenced during the year.

3. PUBLIC CLEANSING

The weekly refuse collection service was maintained during the year. Controlled tipping continues satisfactorily at Appleshaw.

4. SANITARY INSPECTION OF THE AREA

Inspection for Nuisances	32
Drainage Tests	135
Rooms Disinfected	4
Inspection of Water Supplies	387
Dairy Inspections	2
Inspections of Moveable Dwellings	33

5. SHOPS

No statutory action was taken during the year.

6. CAMPING SITES

Licences were issued under the Public Health Act, 1936, to 27 persons to station and use moveable dwellings which exclusively were trailer caravans. Three applications for licences were refused, on account of bad condition of the structures.

7. ERADICATION OF BED BUGS

No cases of bed bug infestation came to the Council's notice.

8. FACTORIES

Inspections for purpose of provisions as to health (including inspections made by Sanitary Inspector).

Premises	Number on Register	Number of Inspections	Number of Written Notices
(i) Factories in which Sections 1, 2, 3, 4 or 6 are to be enforced by Local Authority	8	6	—
(ii) Factories not included in (i) in which Section 7 is enforced by the Local Authority	23	18	—
(iii) Other premises in which Section 7 is enforced by Local Authority (excluding outworkers premises)	—	—	—
TOTAL	31	24	—

Particulars	No. of cases in which defects were found			
	Found	Remedied	Referred To H.M. Inspector	By H.M. Inspector
Want of Cleanliness (S.1)	1	1	—	—
Overcrowding (S.2)	—	—	—	—
Unreasonable temperature (S.3)	—	—	—	—
Inadequate ventilation (S.4)	—	—	—	—
Ineffective drainage of floors (S.6)	—	—	—	—
Sanitary conveniences (S.7)				
(a) insufficient	—	—	—	—
(b) unsuitable or defective	—	—	—	—
(c) not separate for sexes	—	—	—	—
(d) other offences	—	—	—	—
TOTAL	1	1	—	—

SECTION D

HOUSING INSPECTIONS

1. (a) Total number of dwelling houses inspected for housing defects (Public Health and Housing Acts)	84
(b) Number of inspections made for the purpose	123
2. (a) Number of dwelling houses (included under 1.) which were inspected and recorded under Housing Consolidated Regulations 1925 and 1932	33
(b) Number of inspections made for the purpose	33
3. Number of dwelling houses found to be in a state so dangerous or injurious to health as to be unfit for human habitation	11
4. Number of dwelling houses (exclusive of those referred to under the preceding sub-head) found not to be in all respects reasonably fit for human habitation	22

HOUSING ACTION

Remedy of Defects during the year without service of formal notices :—

Number of defective dwelling houses rendered fit in consequence of informal action by the Local Authority or their officers	14

ACTION UNDER STATUTORY POWERS DURING THE YEAR

A. Proceedings under Section 9, 10 and 16, Housing Act, 1936.

1. Number of dwelling houses in respect of which notices were served requiring repairs	Nil
2. Number of dwelling houses which were rendered fit after service of formal notice :—	
(i) By owners	Nil
(ii) By Local Authority in default of owners	Nil

B. Proceedings under Sections 11 and 13 Housing Act, 1936 :—

1. Number of dwelling houses in respect of which Demolition Orders were made	Nil
2. Number of dwelling houses demolished in pursuance of Demolition Orders	Nil

c. Proceedings under Section 12 of Housing Act, 1936 :—

1. Number of separate tenements or underground rooms in respect of which Closing Orders were made	Nil
2. Number of separate tenements or underground rooms in respect of which Closing Orders were determined, the tenement or room having been rendered fit	Nil

HOUSING ACT, 1936. PART IV. OVERCROWDING

A.	(i) Number of dwellings overcrowded at end of year—Estimated	30
	(ii) Number of families dwelling therein—Estimated	50
	(iii) Number of persons dwelling therein—Estimated	150
B.	Number of new cases of overcrowding reported during the year	2
C.	(i) Number of cases of overcrowding relieved during the year	1
	(ii) Number of persons concerned in such cases	6

D. Particulars with respect to overcrowding conditions upon which the Medical Officer of Health may consider it desirable to report :—
No special circumstances.

SECTION E

INSPECTION AND SUPERVISION OF FOOD

(a) Milk Supply

Number of Registered Distributors	1
Number of Registered Distributors outside area selling milk within the area	7

Practically all the milk consumed in the district is supplied by large retail dairymen with pasteurising plant, whose dairies are situated in the Borough of Andover or in Wiltshire County Districts.

(b) Slaughterhouses

There is one licensed slaughterhouse but no slaughtering other than pig killing for private individuals is carried on. There are four butchers shops including the N.A.A.F.I. shop at South Tedworth, all of which are maintained in a clean condition.

(c) Ice Cream

There are 37 registered retailers of ice cream. All these retailers except 2 sell prepacked ice cream. All ice cream sold is obtained from reputed distributors outside the district.

(d) Cafes and Food Preparation Premises

Regular visits were paid to roadside transport and other cafes. Work commenced on the construction of a new bake-house to replace a most unsatisfactory building used in one village.

The absence of piped water and sewerage in villages is not encouraging to owners of food shops to carry out those alterations necessary to achieve the high standard of personal hygiene required for food handlers.

Many food shops cannot be provided with the facilities of sinks and drainage because of confined space and the impracticability of siting a cesspool. This position is especially aggravated when the premises are in low lying situations.

(e) Food Inspection

The following foods were condemned during the year :—

1.	Miscellaneous canned foods ..	55 tins
	Miscellaneous bottled foods ..	12 bottles
	Imported Ham	1 tin (12 lbs.)
2.	Home killed meat—	

Two hindquarters of beef.	Cause of Condemnation	
	Putrefaction ..	136 lbs.
		112 lbs.
		248 lbs.

(f) Adulteration

The Council is not a Food and Drugs Authority under the Food and Drugs Act, 1938.

(g) Food Poisoning Outbreaks

There were no recorded outbreaks of food poisoning during the year.

ANDOVER RURAL DISTRICT COUNCIL

REPORT OF
SURVEYOR AND CHIEF SANITARY INSPECTOR

To the Chairman and Members of the Andover Rural District Council :

Mr. Chairman, Ladies and Gentlemen,

I have the honour to present my fifth Annual Report, for the year ending 31st December, 1952.

HOUSING

Action under the Housing Act, 1936, for the repair or reconditioning of insanitary houses has been confined to those houses becoming vacant as a result of the allocation of new houses to their occupiers. Routine inspection of such houses is made, and where, in my opinion, necessary works of repair would cost an unreasonable amount, representation has been made, to you, for action under Section 11 of the Act.

The decision to make such representation, owing to the high cost of building repairs, is not easy. Even works of comparatively minor repair can, in comparison with the rent, become unreasonable from a financial standpoint.

Undertakings not to relet upon vacation of houses by their occupiers were accepted in respect of eleven dwellings.

Application for grant under the Housing Act, 1949, was received in respect of only one house during the year. The application was subsequently approved by the Ministry of Housing and Local Government.

Absence of piped water supplies and sewerage continues to necessitate deferment of progressive reconditioning.

There were 69 new houses erected, 60 by the District Council, and 9 by private enterprise. In addition to this figure, a considerable number of new W.D. Married Quarters were completed at Barton Stacey and Tidworth.

Properties under the control of this Council for housing purposes at the end of the year were as follows :—

Permanent traditional houses (pre-war)	156
Permanent traditional houses (post-war)	379
Prefabricated temporary bungalows	32
Requisitioned houses (family units)	9
Converted ex-service hutments	177
	753

In spite of the fact that some 597 family units of accommodation have been provided by the Council since the war, the list of applications for Council Houses seems not materially to diminish. It is to be hoped, however, that, with the considerable building envisaged within the next two or three years, the situation will improve rapidly.

Converted ex-service huts continue to deteriorate.

BUILDING LICENSING

Licences were granted during the year as follows :—

(a) New houses—private enterprise	36
(b) Conversions and adaptations	7
(c) Other work	59

By raising the limit within which work can be carried out free of building licence to £200, the central government considerably improved the position, and works of normal repair do not now fall within the scope of building licensing.

No application for a licence was refused during the year, though deferment for some three to four months was necessary during the early part of it.

BUILDING BYELAWS

Plans submitted for approval under your Building Byelaws totalled 123, all of which were approved.

TOWN AND COUNTRY PLANNING

During the year 170 development applications were dealt with by the County Council, as Planning Authority, as follows :—

Applications approved	144
Applications refused	8
Applications withdrawn	3
Applications permitted development	3
Applications pending	12
	170

There were 5 appeals against the decision of the County Council which were subsequently heard, at the Council Offices, and 4 of the appeals were allowed by the Ministry of Housing and Local Government.

WATER SUPPLY

Samples of water taken for bacteriological examination during the year totalled 269, of which 221 were reported satisfactory, 12 not entirely satisfactory and 36 unsatisfactory.

Routine chlorination of the Vernham Dean and Faberstown public supplies continued.

A major breakdown of the pumping plant at Faberstown necessitated the installation of a new electric submersible pump, in June. Some parts of the area of supply were without water for a short time, and it was necessary to convey water to these areas, but no serious inconvenience occurred.

There were 4 known new boreholes sunk in the district during the year.

Regional Scheme

The result of the Public Inquiry into a regional scheme of water supply for the district, held in Novemeber, 1951, by one of the Inspectors of the Ministry of Housing and Local Government, was made known in July, 1952.

The scheme is approved by the Minister in principle, with the proviso that, instead of supplying the parishes of Abbotts Ann, Upper Clatford, Goodworth Clatford, Wherwell and Chilbolton from the Andover Borough source, these parishes should also be served from the Council's new source at Ibthorpe.

Authority was given to order pipes, and to proceed with the preparation of drawings, etc.

It is the intention to supply Smannell by an extension of the Andover Borough Council's Statutory area of supply and negotiations were proceeding with that authority to that end.

Barton Stacey and Bullington

The major portion of this scheme was completed during the year, and water was made available to the new W.D. Estate during April.

A full supply was available to both villages during December.

MAIN DRAINAGE

Valley of the Pill Hill Brook

Approval in principle to this scheme was received from the Minister of Housing and Local Government in July, 1952, but the scheme is to be deferred pending the completion of a scheme of water supply for this area.

Shipton Bellinger

A scheme of sewerage and sewage disposal was prepared by the Council's Consulting Engineers and forwarded to the Ministry of Housing and Local Government for consideration, agreement having been reached with the Laundry Company regardingthe discharge of its Trade Waste into the proposed sewer.

Faberstown

At the end of the year some 90% of the house drains had been connnected with the new sewer.

Barton Stacey

Following the submission of an outline scheme of sewerage for this parish to the Ministry of Housing and Local Government, notification from that Ministry was received to the effect that such a scheme could not be entertained at that time. Further representations were made to the Minister, and as a result authority to proceed with the scheme was given. The Council s Consulting Engineers were therefore instructed to prepare detailed drawings etc., for the invitation of tenders.

Schemes of sewerage and sewage disposal for the parishes of Hurstbourne Tarrant and Longparish are progressing.

MOVEABLE DWELLINGS

Licenses for the stationing of 27 moveable dwellings were issued by the Council during the year.

3 applications for licenses were refused.

REFUSE COLLECTION AND SALVAGE

A weekly collection of refuse and salvage continues.

The amount of material collected was substantially increased by the inclusion within the area of collection of certain W.D. Camps not previously served. During the winter months, with the increase in amount of ashes collected, the service is strained almost to capacity thereby.

The position regarding staff has improved, and the men have generally worked as a good and willing team.

The amount of salvageable material collected and sold during 1952, was as follows :—

	Weight				**Value**		
	Tons	cwts	qrs.	lbs.	£	s.	d.
Baled paper and cardboard	72	12	2	0	739	1	5
Rags and sacking ..	4	13	2	22	92	16	0
Metals	14	8	1	23	130	13	9
Total	91	14	2	17	£962	11	2
Jars and bottles ..	1165¾ dozen				41	16	9
				Total	£1004	7	11

The value of such sales has considerably diminished, owing to the very large drop in the value of waste paper.

RODENT CONTROL

In April, the Council decided to appoint a Rodent Inspector to inspect properties, especially farmland in order to fulfil the obligations imposed upon it by the Prevention of Damage by Pests Act, 1949.

The system of charging for the destruction of rats on other than business premises was found to be unworkable and a free service for householders was commenced forthwith.

It is my opinion that the free service is well worthwhile, for the co-operation of the public is readily elicited, an important factor in eliminating rats on adjoining properties.

The inspection of farmlands was carried out with excellent co-operation from farmers and it was felt that constructive progress had been made.

The following report was submitted to the Ministry of Agriculture and Fisheries for the year 1952 :—

	Local Authority (1)	Dwelling Houses (2)	Agricultural (3)	All other (including business premises) (4)	Total (5)
1. Total number of properties in Local Authority's District	14	3567	178	218	3977
2. Number of properties inspected by the Local Authority during 1952 as a result of (a) notification	(a) 2	147	15	25	189
(b) survey or otherwise	(b) 12	1138	120	77	1347
3. Number of properties inspected (see Section 2) which were found to be infested by rats ..	Major 1	—	14	6	21
	Minor 6	173	30	19	228
4. Number of properties inspected (see Section 2) which were found to be seriously infested by mice	—	33	—	7	40
5. Number of infested properties (see Sections 3 and 4) treated by the Local Authority	7	204	7	32	250

6. Number of notices served under Section 4 : (1) Treatment .. .. (2) Structural Works (i.e. Proofing)	Service of statutory notices after informal action was found to be unnecessary
7. Number of cases in which default action was taken by the Local Authority following the issue of a notice under Section 4	— — — — —
8. Legal Proceedings	No legal proceedings were necessary
9. Number of " block " control schemes carried out	Inspection of 13 parishes including farmland was carried out

In conclusion I would wish to pay a tribute to the work of the members of my staff, both technical and clerical, internal and external, during the year, and to thank them for their willing co-operation at all times.

I have the honour to be,

Ladies and Gentlemen,

Your obedient servant,

R. J. RICHARDS,

Surveyor and Chief Sanitary Inspector.